America the Violent: Child Abuse and Neglect

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Part I of a two-part series, this [course] provides an overview of violence in America, with a focus on features and forms of child abuse and neglect. Critical aspects of assessment and intervention with victims and perpetrators are outlined, together with effective strategies for therapeutic intervention. Part II follows from this discussion and concentrates on assessment and intervention in domestic violence.

Overview of Violence in America

The U.S. ranks first among industrialized nations in violent death. In addition, at least 2.2 million Americans are victims of violent injury each year. In 1991, the U.S. Dept. of Health and Human Services reported that deaths caused by violent and unintentional misuse of firearms exceeded in number the combined total of the next 17 nations. In 1995, according to the National Center for Health Statistics, there was a 21.5% increase in firearm deaths in the period of just ten years. Suicide and homicide together account for the 4th leading cause of death to people under 65 in the U.S., while gunshot wounds (both self- and other-inflicted) constitute the 2nd leading cause of death among people between the ages of 10-34. Violent death and abusive behavior are an important cause of injury-related death and long-term disability. For many women and girls in America, physical assault, sexual assault and rape form an almost continuous, daily threat.

Violence in families is being recognized as highly prevalent and is viewed as a significant factor in the overall health of individual family members. From the vantage point of health care providers, the morbidity and mortality associated with domestic violence is quite high: A woman is beaten every 9 seconds and the National Clearinghouse on Domestic Violence has reported that this violence accounts for more women with injuries needing treatment in emergency rooms than for non-marital rapes, muggings, and traffic accidents combined. The yearly prevalence rates in the United States of physical partner abuse from men to women are estimated to be 16% of all married and cohabiting couples; the lifetime prevalence rates range from 25-50%. In terms of woman-to-man or reciprocal abuse, the best estimates so far indicate a reciprocal violence rate of 12% of all heterosexual couples in which there is violence and about a 1% rate of all cases in which there is solely woman-to-man violence. In terms of prevalence rates among gay and lesbian couples, the best available data indicate that these couples are not immune to violence among intimates, although their actual rates, types of injuries and experiences in receiving treatment have yet to be studied adequately.

There also appears to be a relationship between sex and violence in America. Social scientists have emphasized the role of cultural expectations and interests in terms of a national character that is focused on sensation-seeking and the rights of individuals to have freedom of expression, including sexual expression. The democratic values of freedom of speech and freedom of the press has been interpreted to protect media materials that are ever more graphic in terms of both sex and violence. Although there is concern about the role of television and the film media in shaping the behavior of children and adolescents, there have been few legislated mandates that limit the proliferation and accessibility of these materials. The 1980's and 1990's yielded considerable discussion of the increases in teenage sexual activity and teenage violent behavior and the purported influences on these trends. While researchers, teachers, counselors, and legislators continue to discuss possible effects of the media without consensus, victims of violence and violent sex continue to present to the health care system. What is clear is that many victims are injured by their intimate others. Every day in America at least four women die as a result of violence perpetrated by a man who is or was a romantic partner. The National Center for Disease Control has identified a direct link between battering and the spread of HIV and AIDS among women (Jones, 1994).

National Objectives for Reducing Violence and Abusive Behavior

A national focus was developed in 1985 by the Surgeon General and U.S. Public Health Service to focus on violence as a leading public health problem. The federal government has an involvement through the U.S. Dept of Health and Human Services, with the goal of reducing various forms of family violence. Specific objectives center on six key areas:

1. Homicide and Assaultive Violence
2. Domestic Violence (partner and elder abuse)
3. Child Abuse
4. Sexual Assault
5. Suicide
6. Firearm Injury

Several foci are to be emphasized in national health policy, including establishing effective services for victims that address the physical and psychosocial consequences of abuse.

Victims of Violence and the Health Care System

In general, health care providers, including behavioral health professionals, appear to underestimate the influence of family abuse and violence in their patients. The lack of structured, systematic approaches to diagnosis in this area, along with a "conceptual blind spot" about the prevalence of abuse, may contribute to these diagnostic omissions. It is also true that many professionals have strong emotional reactions to abuse issues and that it is an area difficult to manage, so ignorance is less stressful than recognition and confrontation. In some ways, abuse can be compared with substance abuse; all professionals know that the problem exists, but it is common to attribute it to someone else's arena rather than to one's own. Although the 1970's to the 1990's have generated intense interest and study of violent behavior and victimization, there has not been a corresponding development of programs that have succeeded in putting fewer people at risk.

Clinicians in many fields, then, need to be sensitive to the possibility that many patients' symptoms or injuries may be abuse-related. Providers need access to protocols for accurate diagnosis of various types of family violence:

- Elder Abuse
- Child Abuse (emotional, physical, and sexual)
- Spouse/Partner Abuse

The goal of assessment is to have a high degree of sensitivity to situations in which abuse is present. Interviewing approaches that assist in identifying violence without immediately alienating family members are essential. The roles of psychotherapists, physicians, state protection agencies, and the judiciary, need to be clarified and methods developed to integrate services. Each area has its role in identifying abuse when it occurs, instituting protective measures for all involved, and developing effective treatment and rehabilitation modalities. It is also important to recognize that providers' concerns about possible abuse are influenced by the sociocultural characteristics of patients. Families from different sociodemographic groups may trigger differential responses in health care providers. Difficulties encountered by providers with different life experiences and/or ethnic or social backgrounds from their patients are important variables to study in the area of family violence.

There appear to be field-specific barriers that serve to reduce the likelihood of the detection of family violence. For instance, primary care physicians and emergency room physicians are often the first contact point for victims after they have experienced family violence, yet recent empirical studies have demonstrated that physicians often are not identifying patients who are victims of

abuse. Although competing demands of critically ill patients and time factors may be the major barriers, lack of structured protocols for evaluation clearly play a part. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated that all emergency departments and ambulatory care facilities have guidelines for the identification, evaluation, management and referral of adult victims of domestic violence. In psychiatry and psychology, there has been a long-standing tradition of focusing on the individual patient or client and on intrapsychic functioning, rather than emphasizing the person in the context of their family relationships, friendships and associations, or community networks. From Freud's time, when women's neuroses were assumed to emanate first from actual sexual encounters and then from imagined romantic and sexual liaisons, most psychotherapists have preferred to believe that abuse was not a common experience of children. Most theories and research on lowered self-esteem and resulting psychological distress or disorders omitted one significant cause of this self-evaluation: chronic and persistent devaluation and de-humanization of one person by another. Gradually, however, it has become evident to all partners in the allied health care professions that physical and sexual assault by family members is a frequent experience of children and teenagers, as well as adult women. In order to develop protocols and overcome barriers to the recognition and understanding of victimization, the following outline details material about several forms of family violence. Definitions, selected assessment techniques, and common presentations are included for each area.

A general definition of family violence includes those acts that result or are likely to result in physical injury (Straus, 1980). Additionally, a family is defined as "violent" if at least one violent act occurred within last year (Straus and Gelles, 1986). Acts of severe violence have a high likelihood of causing serious injury, such as kicking, biting, punching, hitting with an object, "beating-up," and attacking with knife or gun. Acts of minor violence have a potential for causing serious injury, for example: pushing, shoving, slapping, and throwing things. In terms of emotional abuse, words and threatening behavior can inflict psychological trauma and injury rather than physical injury. Emotional abuse often coincides with physical and sexual abuse but can have lifelong, damaging sequelae on its own. Sexual abuse can be physically traumatizing or can include acts that do not injure physically, but invade a person's dignity, choice, and sense of safety.

Child Abuse and Neglect

Incidence and Patterns

The National Committee to Prevent Child Abuse noted that in 1996, over three million reports of neglect and child abuse occurred nationwide, constituting a report of abuse for approximately 47 out of every 1,000 children. In terms of substantiated reports, the corresponding numbers are about 1,000,000 cases or about 14 of every 1,000 children. In terms of types of abuse over the years, physical maltreatment accounted for the highest percentage of confirmed cases, followed by sexual abuse, and emotional abuse. Approximately 1,000 fatalities occurred as a result of abuse and neglect (approximately three each day), with neglect comprising about 45% of cases, physical abuse accounting for about 52%, and both physical abuse and neglect combined account for the remainder. The Center for Disease Control and Prevention estimates that neglect kills 5.4 out of every 100,000 children age four and under per year (McClain, Sacks, Frohlke, 1993). Fatalities from physical abuse most often occur from severe head trauma, shaken baby syndrome, trauma to the chest or abdomen, scalding, drowning, suffocation, and poisoning.

Note: It is impossible to determine the true incidence of abuse, as the vast majority of cases remain unreported.

Looking at the problem from another perspective, approximately 50% of the deaths of children are due to traumatic injuries, many of which are due to physical abuse and assault. Paut, Jouglet & Camoulives (1997) and Marshall (1997) found that the rate of hospitalization for abused children was about 10 per 100,000 of the child population per year and concluded that most treatment of injuries related to child abuse occur in the ambulatory care sector.

Indicators

All clinicians who see children in their practice need to be sensitized to the most frequent presenting signs of abuse, including visual bruises, lacerations, burns, fractures, or human bite marks. The vast majority of injuries due to striking or hitting occur about the face, neck and shoulders.

> **Bruises and Welts** occur on the mouth or other areas of the face, or on the areas of the chest, back, buttocks or backs of the legs. Bruises that are in various stages of healing indicate injuries that occurred at different times and any unusual patterns of injuries for accidental injuries should be noted. Also, often an imprint of an object that was used to abuse (an iron, a shoe) can be detected on the skin.
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> **Lacerations and abrasions** are most commonly found on the mouth, lip, gums, or eye or the external genitalia when they are abuse-related.
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> **Burns** are most often of two categories, those produced by cigars or cigarettes and those that are produced by immersion in scalding water, such as glove burns or sock burns on hands or feet or doughnut-like burns on the buttocks.
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> **Fractures** due to abuse often involve the skull, jaw or nasal areas or spiral fractures of the long bones (arms or legs), or multiple fractures. They are often distinguished by being fractures in various stages of healing and especially any fracture of child under age two; children of this age do not often get accidental fractures except due to falls.
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> **Human bite marks** constitute one other possible means of abuse and children must be questioned sensitively but carefully about the perpetrator of a bite.

There are myriad [of behavioral] signs that could be indicative of abuse, but could also be related to other health problems, personality styles, or psychosocial stressors. Some of the ones noted in the literature include small children who:

- Shy away from physical contact with adults
- Seem frightened of their parents or caretakers
- Appear apprehensive when other children cry

Children may directly report injury by the parent or caretaker and all children need to be regarded as credible witnesses and a further investigation initiated.

In terms of behavioral descriptions, abused children often fall on one side of a continuum of extremes by showing either extreme aggressiveness or extreme withdrawal. In terms of school and social behavior, the child may display:

- Overt behavioral problems
- A higher level of truancy or missed days than is the norm

- May begin a pattern of delinquency, including vandalism, running away, prostitution, or drug use

Characteristics of Abusive Parents

Researchers have noted prominent characteristics of abusive parents. Mostly, these parents are "common folk," who are overwhelmed by the role of parenthood or by multiple responsibilities of work life and home life. In terms of assessing parents on an individual level, several factors should be considered, including:

- Being an abuse victim him/herself
- Having a high level of dependency needs
- Being a substance abuser
- Having low impulse control
- Having ineffective defense mechanisms
- Having low self-esteem
- Being prone to externalizing blame to others or projecting problems onto others
- Being easy to anger

The interpersonal style of the abusive parent may be cold and rejecting, but may not be frankly psychopathological.

It is also essential to assess the parents on a cultural level, including their general beliefs and attitudes about child-rearing and their views of discipline, especially dealing with crying, potty training, and the effectiveness or necessity of corporal punishment. Most parents who abuse children use harsh discipline that would be judged by child behavior experts as inappropriate to the child's age or the particular transgression (e.g., spanking a two year old child for spilling milk). The parent may also inappropriately see the child as bad, evil or monster-like and often blames and belittles the child.

According to Salzinger, Kaplan and Artemyeff (1983), parents who neglect or abuse are more likely to have:

- Higher incidence of drug and alcohol use
- Antisocial personalities
- Labile personalities
- Low self-esteem
- A need a child’s compliance to feel competent

Note: Less than 10% of persons who are psychotic abuse their children, the vast majority of emotionally disabled parents can take adequate care of children.

Abusive parents also have difficulty with appropriate empathy toward the children’s perspective and expect them to behave in ways that are not congruent with their developmental level (Steele, 1980).

According to the National Clearinghouse on Child Abuse and Neglect Information, there is not a clear profile of who may abuse a child. However, abusive parents may have the following situations/characteristics:

- Young adult in mid-20's
- Poverty
- No high school diploma

- Experienced violence themselves
- Depressed and unable to cope with stress

Another important facet of abuse, according to the Clearinghouse, is the presence of "triggers" that precede acts of abuse that result in an infant or child's death:

- An infant's chronic crying
- Feeding problems
- Toddler's problems with toileting
- Exaggerated parental perceptions of child's disobedience

Levels of Premorbid Factors in Abusive Parents and Family System

Psychotherapists need to look at several different levels of the family system when interviewing families, including:

- Individual parental level and parental characteristics
- Cltural level, examining beliefs about child rearing and discipline
- Couple or familial level
- Social network

The first two levels were previously described under "Characteristics of Abusive Parents." At the couple or familial level, the clinician may find:

- An unstable or highly conflictual marriage or relationship
- Partner abuse
- Social isolation from other support networks, such as extended family relationships
- Chaotic family
- Family may be under severe stress due to financial or social problems
- Family may have several chronic illnesses in family

On the social level, abuse is more likely to occur when:

- There is inadequate social support from the neighborhood, school, or church
- Persistent poverty, including inadequate housing
- Unemployment
- No or inadequate daycare or other child care assistance

Many health professionals assume that all types of abuse are associated with poverty. A recent study by Drake and Pandey (1996) noted that neighborhood poverty is most positively associated with neglect, and less powerfully associated with physical abuse and sexual abuse. When children are being evaluated for potential abuse, studies have shown that approximately 30-50% of their mothers will also be victims of spouse or partner abuse (Wright, Wright and Isaac,1997).

Psychotherapists often entertain stereotypes about what types of families might be more likely to include abuse of children and one stereotype is that of the patriarchal, aggressive, rigid family of military personnel. On empirical evaluation, however, recent reports have documented a lower, not a higher, level of abuse among military families. (Mollerstrom, Patchner & Milner, 1995; Raiha and Soma,1997).

Child Sexual Abuse

Sexual child abuse occurs when a person enlists or forces the participation of children or teenagers in sexual activities inappropriate to their cognitive and emotional level of maturity. Because children are not developmentally ready to offer consent for these activities, the activities are regarded as coercive even if they do not involve the use of force. Sexually abusive activities can range from visual or noninvasive activities such as exhibitionism of an adult, to coercing the child's participation in sexually explicit pictures or films, to fondling by or of the adult, to brutal penetration of bodily orifices.

The detection or diagnosis of sexual abuse for purposes of referral requires less than documentation for legal cases. For purposes of referring the child or family to protective services or for counseling, the provider need only have a suspicion that sexual abuse has occurred, although reporting laws may vary by state and type of provider. From a legal perspective, documented physical evidence is required, as is identification of abuse by the victim, or acknowledgement by the child abuser. Since a physician or counselor is often the first person to interface with a patient or family when abuse has occurred, it is essential that appropriate interviewing techniques and sufficient documentation occurs at the outset in the event that a legal case can be pursued.

Incidence and Patterns

It is debatable whether the incidence of sexual abuse is rising or if there is an increased emphasis placed on the problem by health officials. A report compared statistics in the 1970's and 1980's to those reported by Kinsey's work in 1953 and concluded that the most methodologically sound projects yielded results of no significant increase in child sexual abuse. Across time, approximately 10-12% of girls younger than 14 experience sexual abuse by a perpetrator at least 5 years older than the girl. Other researchers have estimated that incidence to be closer to 25% for girls and 10% for boys. For instance, Gorey and Leslie (1997) reported that the childhood rates of sexual abuse was 22.3% for females and 8.5% for males based on surveys spanning three decades. It is important to emphasize that sexual abuse is color-blind and income-blind. Although studies have found variability in patterns of abuse among different ethnic groups (Huston, Parra, Prihoda & Foulds, 1995; Mennen, 1995), most findings do not corroborate the popular myth that ethnicity and socioeconomic status are strong influences on sexual abuse.

Presentations of Abuse

There are often no clear symptoms of sexual child abuse: Children are often coerced into secrecy, so obtaining information about abuse or the cause of injuries is difficult. Finkelhor (1979) reported that only 35% of children who are sexually abused ever report it to anyone. Reporting is related to many factors, such as the relationship of the abuser to the victim or the victim's family, the age of the perpetrator, and the perceived consequences of disclosure. The symptoms of sexual abuse are often general and nonspecific, such as sleep problems, phobias, enuresis, or encopresis. Psychological symptoms of abuse include lowered self-esteem, mistrust of adults, guilt, depression, suicidal ideation, delinquency, acting out, and running away. A smaller percentage of children who are abused will have more specific signs and symptoms: rectal or genitalia pain, bleeding or infection, STDs, and developmentally precocious sexual behavior.

Assessment

Health care professionals are urged to consult the guidelines for interviewing published by the American Academy of Child and Adolescent Psychiatry. Drawings, dolls, and other interviewing aids can be helpful, especially with very young children. However, the provider should check rules in each state; some jurisdictions consider these to be "leading the witness," and may ruin a case against a perpetrator in court. The interviewing style should include: (a) Using nonleading

questions, (b) Maintaining a calm, unemotional but empathic demeanor, (c) Supporting and prompting the child with nonverbal behavior, with an open demeanor and focused attention, using paraverbal signs (e.g., "uh huh," "go on," "okay," "yes") and (d) encouraging the child with verbal statements (e.g., "Tell me more about that." "What happened after that?") In general, parents and other caretakers should be interviewed separately. However, if a child is very shy or appears fearful, interviewing them with a supportive adult not implicated in the abuse may be indicated.

Other issues revolving around assessment include estimates that the majority of victims initially deny abuse and of those who disclose it, up to 25% eventually recant their statements. Sorenson & Snow (1991) propose a process that involves stages of disclosure and includes states of denial, reluctance, disclosure, recantation and reaffirmation. Bradley and Wood (1996) did not find these patterns to be the case and found that denial occurred in only 6% of cases validated by protective services investigators and recanting occurred in 4%. False allegations of abuse have become an issue, especially during divorce, custody and visitation hearings. It is important to take all allegations of abuse seriously, but to realize that in custody considerations up to 25% of allegations may be false.

It may be useful for therapists to inquire about sexual abuse (in a screening modality) without ever mentioning the word "sex." Two sets of statements and questions can address this area with children in a sensitive and noninvasive manner. These statements/questions prompt questions or statements from children who have been sexually abused:

- *As a counselor, I know that kids have a lot of questions about certain things. Do you have any questions about your body or kid's bodies? And how they work?"*
- *Adults have bodies that are different from kids. Do you have any questions about adult's bodies? and how they work?*

Children who have been sexually abused are very likely to have questions or make statements that indicate abuse. For example, "*Why does Uncle Joe want to put his pee pee on me?*" or "*How come George's private parts are so much larger than mine?*" Asking children to draw pictures of "a boy" or "a girl" and "a man" and "a woman" is often very instructive in children who have been sexually abused, as they often present details (such as sketches of genitalia) that may prompt the astute clinician to have a higher suspicion of abuse.

Families undergoing evaluation of sexual abuse may need mental health services. Children who have been sexually abused often need supportive counseling. More extensive or in depth treatment depends on the extent of the abuse (how violent, how long it occurred, and the closeness of the relationship of the child to the abuser). Parents and other family members, such as siblings, also require counseling; the extent of this depends on whether the situation involves an intrafamilial abuser or if the children were victims or witnesses of abuse.

What Psychotherapists Can Tell Parents and Children about Physical Examinations regarding Potential Abuse

Parents or caretakers can be told that physicians, nurse practitioners, or forensic nurses will try to avoid further emotional trauma while examining a child. It is ideal if the physician can perform the exam in the presence of a supportive adult not suspected in the abuse. The exam focuses on trauma in areas involved in sexual acts: mouth, breasts, genitals, perineal area, buttocks and anus. Although many victims of sexual child abuse will have no physical signs of abuse, it is important to document signs if they are present.

Physical Findings Suggestive of Sexual Child Abuse (American Academy of Pediatrics, 1991):

- Chafing, abrasions, or bruising of the inner thighs and genitalia
- Scaring, tears, or distortion of the hymen

- Decreased amount of or absent hymenal tissue
- Scarring of the fossa navicularis
- Injury to or scarring of the posterior fourchette
- Scarring or tears of the labia minora, and
- Hymenal enlargement (see Cantwell, 1987)
- Bruises around anus
- Scars and anal tears, especially those that extend into surrounding perianal skin
- Anal dilation and visual sphincter laxity

Determine the source of any genital trauma is important. It can include accidental injury, physical abuse, infectious processes, and congenital malformations. The physician obtains a detailed history and consults with colleagues if the etiology is unclear. A regional child protection team or other experts can be consulted in case of confusing or contradictory findings. Physicians do not complete cultures for STDs routinely, only if history or physical findings suggest the possibility of direct contact. It is important to alert parents and children to other aspects of the examination if there is evidence available that might help in the prosecution of a perpetrator. The child will be asked to have photographs taken of injuries, including those to areas that would be covered by a bathing suit; it is important to explain to the child the necessity for this and to let them express how this could be done in a manner most comfortable for them (letting them play with the camera or taking a picture themselves can be a good icebreaker). Also, they may be asked to have blood or urine samples taken, and if old enough, to have pubic hairs combed. The clinician's examination and report include detailed records, drawings or photographs and any serum or tissue samples collected. Written reports to county agencies and law enforcement are often completed.

Focus on the Perpetrators

In reporting on a national survey of adults and inquiring about abuse, Finkelhor, Hotaling, Lewis, and Smith (1990) sketched out many parameters of abuse perpetrators and victims. For instance, according to most data that we have in the United States, familial incest is more common than stranger molestation. Some researchers have theorized that sexual abuse may be more prevalent than physical abuse or battery, but simply goes unreported at a higher rate. In addition, studies have indicated that the median age of the child when abuse occurs is 11 years of age, and the peak age of vulnerability is between 7 and 13. Ten girls are molested for every one boy; while males constitute over 90% of the abusers of both genders of children (Finkelhor, 1994). Seventy-five percent of the offenders were known to the child or family, meaning that less than 25% were total strangers; about 30% lived in the home (father, stepfather, mother's partner, brother) and another 11% were related by blood or marriage. For girls, one-third to one-half of the perpetrators were family members, while for boys, only 10 - 20% were related. For perpetrators of abuse against girls, fathers comprised 27 percent of one sample, evenly divided between biological fathers and stepfathers.

In general, younger men molest children. One study showed that, of approximately 100,000 total arrests for all kinds of sexual offenses, the highest number of perpetrators were 20-24; the second highest were 15 to 19 year olds. In another study, the offenders ranged in age from 17 to 68 years, with a median of 31 years; more than 30% were under 24, 60% were under 34 and only 10% were over 50. Thus, the cultural stereotype of a "dirty old man" is empirically incorrect. This is not to dispute that there are some elderly pedophiles, just that they are not the norm for child abusers. In more than 40% of cases of sexual abuse by adults, abuse continued from weeks to years. Force or the threat of force was used in 60% of the cases; in 25%, the lure was more subtle, based on the child's natural loyalty and affection; and in 15%, money or gifts were offered. Few pedophilic offenses by adult men involve the threat of a weapon; most often a verbal threat was used to coerce the child. Injuries occur in as many as 45-55% of adult sexual assaults on children.

Alcohol Use and Sexual Assault

Incest can occur in families where alcoholism exists in either the mother or father (Beckman & Ackerman, 1995). The heavy use of alcohol may serve as a disinhibitor to the father's behavior. Excessive alcohol use by a mother may either make her less involved with the father (and thus he uses this as an excuse to turn to the daughter) or may make a mother less vigilant about protecting her daughter. Estimates are that about 50% of rapes are associated with alcohol use by either the assailant, the victim, or both. In the current time, however, the use of other substances (such as the street drugs Ecstasy or Roofies) are often associated with rape and teenage sexual abuse. Teenage males or young men give the drugs to young women to increase the likelihood that they will participate in sexual activities or will not remember the activities.

Adolescents as Sex Offenders

Many child victims of sexual abuse are abused by other children, usually males (95% or more) older than the victims. Davis and Leitenberg (1987) noted that about 20% of all rapes are by adolescents; 30-50% of all cases of child sexual abuse can be attributed to teenage perpetrators; and that half of adult sex offenders report that their first act of abuse occurred when they were a teenager. Longo and Groth (1984) believe that many adolescents practice sexually inappropriate behaviors early and progress to more serious offenses as adults; they estimated the presence of this pattern in 35% of adult rapists. Physical injuries during sexual assaults by adolescents are lower than with adult abusers, about 30% for teen assaults, as compared to 45-55% for adults. With adolescents molesting youngsters, 11% involved weapons. There also may be a higher likelihood of multiple assailants being involved in rape when the perpetrators are 21 or younger as compared to adults.

Psychotherapists should advise parents to select babysitters carefully: About 40-50% of childhood rapes or fondling of young children (6 years old or younger) by male offenders took place while the perpetrator was a caretaker. For women who commit sexual offenses against children, over 60% of the incidents occurred while the woman was a babysitter. Advise parents to choose sitters they know well and have them spend time with the sitters before leaving the children in their care. Notice level of maturity, style of play and discipline, and an appropriate interaction in terms of distance and closeness between sitter and children. In general, males are implicated by their gender as being higher-likelihood abusers.

Which adolescent children are most likely to perpetrate sexual acts against children? Studies have found that 40 - 75% of adolescent sex offenders report a history of physical abuse, physical punishment, or neglect compared to 15% - 30 of other similar or matched delinquents who had committed other crimes (Van Ness, 1984; Lewis, Shanok & Pincus, 1982). Researchers have contended that adolescent sex offenders may lack assertiveness; have poor interpersonal skills or social skills, especially in obtaining or maintaining close friendships; feel rejected by their peers, or be socially isolated (Groth,1977; Abel, Mittelman, Becker, et al 1985; Fehrenbach et al, 1986). However, there has not been a controlled study that pairs adolescent sex offenders with a matched group of nonoffenders on measures of social competence or any other interpersonal skills. For adult rapists in prison, they have not been shown to be different than nonprison men in terms of social competence, assertiveness, anxiety, or many other measures. Although some clinicians suggest mechanisms by which an adolescent might be "primed" to commit a sexual offense against a child, there are no controlled studies to draw from on these matters. Some processes that have been linked to the increased likelihood of an adolescent sexually molesting a child include: having a fantasy life focused on children, having poor anger control or having difficulty with age appropriate sexual relations.

It is important to note that successful, intensive models for the treatment of juvenile offenders have been described. For instance, Knopp (1982) described the use of multi-sector treatment programs for adolescent offenders that provide the following kinds of interventions: academic instruction, daily individual therapy, behavioral education and health instruction; weekly family

therapy; and therapy groups which emphasize taking responsibility for assaultive behavior and explore approved behaviors to replace deviant acts.

Signs and Sequelae of Sexual Abuse on Teens and Adult Survivors

Research studies have documented associations or correlations between sexual child abuse and adult women's low self-esteem, depression, anxiety disorders, self-destructive behavior, posttraumatic stress disorder (including nightmares, insomnia and flashbacks, difficulties in interpersonal relationships, parenting difficulties, sexual dysfunctions and other difficulties, substance abuse and prostitution (Browne & Finkelhor, 1986). A recent study of sexually abused children five years after a presentation of abuse showed that, compared to a control group of similar children, they had disturbed behavior, lower self-esteem, unhappiness and depression, anxiety, binge eating, self-inflicted injuries and suicide attempts (Swanston et al., 1997). One study found that "bodily shame" was an important mediating variable in the relationship between childhood physical and sexual abuse and depression in adulthood (Andrews, 1997). Another indicated that sexual abuse was associated with significantly lowered self-esteem only when it was very severe (Romans, 1996). Other researchers have contented that childhood sexual abuse is the single most powerful predictor of adult emotional disorders (Briere, 1997).

An excellent case-controlled study of adult survivors of sexual assault (Yellowlees & Kaushik, 1994) showed that the survivors were more frequently victims of domestic violence as adults, had a higher rate of suicide attempts, abused alcohol and tranquilizers more frequently, and were more likely to be diagnosed with a personality disorder. Looking at the problem from another perspective, Beckman and Ackerman (1995) documented that heavy alcohol consumption by women was associated with a high incidence of childhood incest, sexual assault and sexual dysfunction. Many women who are psychiatric inpatients have positive histories for childhood physical and/or sexual abuse (approximately 60-80%), yet when they present for treatment, only 10% of patients have incest as the presenting complaint.

Several recent national surveys have further corroborated the sequelae of abuse for young women and found that on nearly every measure of quality of life, abused teens fare poorer. One study released by the Commonwealth Fund found that teenage girls who have been physically or sexually abused are more likely to be depressed, get pregnant, have poor grades, and use nicotine, alcohol or drugs. In Washington state, teen girls who were victims of sexual abuse (which was listed as an incidence of 23 percent) were more than twice as likely to have intercourse and at threefold greater risk of pregnancy. Luster and Small (1997) found that about 10% of adolescent females in a Midwestern state had experienced sexual abuse and that abuse led to a higher level of adolescent sexual activity. If the teens were also physically abused in addition to the sexual abuse, their adolescent sexual activity was even higher. However, previously abused teens with "supportive families" had a lower number of sexual partners when they became sexually active with others. A lower level of sexual activity was associated with families in which: a) parents monitored their teen's activities closely, b) teens experienced high levels of parental support and c) parents disapproved of teenage sexual activity. Following from this, it may be important for psychotherapists to provide anticipatory guidance for the parents of children who have been sexually abused in terms of rules and family ambiance during their teen years.

It is also important to underscore that boys and girls may react differently to sexual abuse. For instance, Chandy, Blum, and Resnick (1997) found that teenage women who had been sexually victimized were more likely to show internalizing behaviors, including suicidal ideation and eating disorders, while male teens were more likely to act out at school and to use alcohol and drugs. It is noteworthy that the vast majority of children who are sexually abused do not present for treatment until many years after the assault, often ten or more years later. The perception of many victims is that certain life events spur memories of past abuse or spur strong emotional reactions about the abuse; events may elicit a delayed post traumatic stress reaction. Beginning a sexual relationship, having a baby, or being examined by a health care provider in areas of the

body touched by the abuse (mouth, genitalia, or anal area) can all elicit a memory or strong emotional response.

Psychological Maltreatment

When psychological abuse occurs in isolation, it often gets overlooked and is usually detected when in combination with other forms of abuse. Different types of emotional abuse include neglect and ignoring the child, separating the child from other family members or friends, terrifying the child by verbal threats, unduly criticizing the child, threatening abandonment and rejection, and inappropriately treating the child as an adult and expecting adult-like behavior and emotions. It is important for the clinician to assess the intensity, frequency and duration of these types of behaviors from an adult caretaker to a child. Even if frank emotional abuse has not occurred, clinicians should use every opportunity to educate parents and caretakers about expected child developmental progress and age-appropriate behavior.

Common sequelae to psychological maltreatment includes psychosomatic symptoms and behavioral changes. It is important for the clinician to ask two questions on each encounter with a child:

1. What is the normal pattern of behavior for this child, and how has the behavior changed?
2. Does this child exhibit signs of excessive anxiety?

For a primary care provider, proper detection and management will increase if:

1. All periodic visits include questions about how the child feels about himself/herself and his/her family;
2. The provider assesses whether the parent has a clear notion of how the child is emotionally functioning; and
3. The provider delivers services to the entire family and thus has a sense of the functioning of all members.

Adult Survivors of Childhood Neglect, Adversity and Physical Abuse

Prigerson et al (1997) noted that childhood adversity, attachment style, and personality styles influenced the development of anxiety disorders as adults. Other studies have clearly documented the presence of a poorer health status as an adult as a sequelae of abuse (Leserman, Li, Drossman et al., 1997), especially rape and multiple life-threatening events. It is clear that some children survive abuse as children with better outcomes than comparable others. Romans (1996) showed that several variables predict low self-esteem in women, including being a follower or a loner, having a controlling mother, not being academically qualified, and having a history of depressive symptoms. The differences between abused and nonabused women were strongest on the dimensions of pessimism and fatalism. Women who present to psychotherapists with dynamics characterized by a strong sense of pessimism should be evaluated for childhood abuse; the potential for cure in psychotherapy is clearly linked to the appropriate focus.

Summary

Violence is a common occurrence in American families and can take a number of different forms.

Clinicians are likely to be exposed to clients who have been victims or perpetrators of some form of family violence. This paper has focused on child sexual abuse and physical and emotional child abuse, outlining some important considerations in the assessment and treatment of these problems. Part II extends this discussion to the area of spouse abuse, focusing on issues of assessment and intervention in domestic violence.

Resources

California

The California Alliance Against Domestic Violence
926 J Street, Suiite 210
Sacramento, CA 95814
Phone: 916-444-7163
Toll Free: 800-524-4765
Fax: 916-444-7165
Web site: http://www.caadv.org/

SafeState
California Attorney General's Office
Crime and Violence Prevention Center
1300 I Street, Suite 1120
Sacramento, CA 95814
Phone: 916-324-7863
Fax: 916-327-2384
Web site: http://safestate.org/

Women's Rights Handbook
Violent Crimes Committed Against Women and Children
Web site: http://caag.state.ca.us/publications/womansrights/ch7.htm#7
This chapter deals with sexual assault; battering of spouses, cohabitants and the parents of one's children; and child and elder abuse. The chapter discusses the legal definitions of each of these violent acts, and gives information on the legal, medical and counseling resources available to survivors of such abuse.

Support Network for Battered Women
1975 W. El Camino Real, Suite 205
Mountain View, CA 94040
Phone: 650-940-7850
TDD: 650-940-7857
24-hour Crisis Line (English and Spanish): 800-572-2782
Web site: http://www.snbw.org

Family Violence Prevention Fund
383 Rhode Island St. Suite #304
San Francisco, CA 94103-5133
Phone: 415-252-8900
Fax: 415-252-8991
Web site: http://endabuse.org/

Center for Domestic Violence Prevention - Bay Area
P.O. Box 5090
San Mateo, CA 94402

24-Hour Phone Line Support: 650-312-8515
National Domestic Violence Hot Line: 800-799-SAFE
Web site: http://www.cdvp.org/main.html

Florida

Community Action Stops Abuse (CASA)
PO Box 414
St. Petersburg, FL 33731
24-Hour Help Line: 727-895-4912
E-mail: info@casa-stpete.org
Web site: http://www.casa-stpete.org/

Florida Coalition Against Domestic Violence
425 Office Plaza Dr.
Tallahassee, FL 32301
Phone: 850-425-2749
Hotline: 800-500-1119
Web site: http://www.fcadv.org/

Florida Council Against Sexual Violence
1311-A Paul Russell Road, Suite 204
Tallahassee, FL 32301
Phone: 850-297-2000
Toll Free Information Line: 888-956-7273
E-mail: information@fcasv.org
Web site: http://www.fcasv.org/

Florida Health and Human Services
Department of Children & Families
Florida Domestic Violence Hotline: 800-500-1119
Web site: http://www.dcf.state.fl.us/domesticviolence/

Betty Griffin House
Serving St. Johns County
24-Hour Crisis Hotline: 904-824-1555
E-mail: shelter@aug.com
Web site: http://www.bettygriffinhouse.org/

Refuge House
Serving 8 Counties: Franklin, Gadsen, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla
24 Hour Crisis Line: 850-681-2111 (Collect calls accepted)
Phone: 850-922-6062
Web site: http://www.refugehouse.com/main.htm

General Resources

National Center for Injury Prevention and Control
Mailstop K65
4770 Buford Highway NE
Atlanta, GA 30341-3724
Phone: 770-488-1506
Fax: 770-488-1667
Web site: http://www.cdc.gov/ncipc/

The U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201
Telephone: 202-619-0257
Toll Free: 877-696-6775
Web site: http://www.hhs.gov/

National Coalition of Anti-Violence Programs (NCAVP)
http://www.avp.org/ncavp.htm

Asian & Pacific Islander Institute on Domestic Violence
http://www.apiahf.org/apidvinstitute/default.htm

National Latino Alliance for the Elimination of Domestic Violence
http://www.dvalianza.org

Institute on Domestic Violence in the African American Community
http://www.dvinstitute.org

Community Insights on Domestic Violence Among African Americans
http://www.hawaii.edu/hivandaids/Community%20Insights%20on%20Domestic%20Violence%20among%20African%20Americans.pdf

Additional State Resources

- Alabama Domestic Violence Crisis and Support Resources
  http://www.aardvarc.org/dv/states/aldv.shtml
- Alabama Coalition Against Domestic Violence
  http://www.acadv.org
- Alaska Network on Domestic Violence and Sexual Assault
  http://www.andvsa.org
- Arizona Domestic Violence Safety
  http://www.supreme.state.az.us/dr/dv/dv.htm
- Arkansas Coalition Against Domestic Violence
  http://www.domesticpeace.com
- Colorado Domestic Violence Coalition
  http://www.ccadv.org
- Connecticut Coalition Against Domestic Violence
  http://www.ctcadv.org
- Delaware Domestic Violence Coordinating Council
  http://www.dvcc.state.de.us/index2.html
- District of Columbia
  http://www.dccadv.org
- Florida Coalition Against Domestic Violence
  http://www.fcadv.org
- Georgia Coalition Against Domestic Violence
  http://www.gcadv.org
- Hawaii State Coalition Against Domestic Violence
  http://www.hscadv.org
- Illinois Coalition Against Domestic Violence
  http://www.ilcadv.org
- Indiana Domestic Violence Crisis & Support Services
  http://www.aardvarc.org/dv/states/inddv.shtml
- Iowa Coalition Against Domestic Violence
  http://www.icadv.org

- Kansas Coalition Against Sexual and Domestic Violence
  http://www.kcsdv.org
- Kentucky Domestic Violence Association
  http://www.kdva.org
- Louisiana Coalition Against Domestic Violence
  http://www.lcadv.org
- Maine Coalition to End Domestic Violence
  http://www.mcedv.org
- Maryland Network Against Domestic Violence
  http://www.mnadv.org
- Massachusetts Coalition Against Domestic and Sexual Violence
  http://www.janedoe.org
- Michigan Coalition Against Domestic and Sexual Violence
  http://www.mcadsv.org
- Minnesota Coalition for Battered Women Projects
  http://www.mcbw.org
- Mississippi Coalition Against Domestic Violence
  http://www.mcadv.org
- Missouri Coalition Against Domestic Violence
  http://mova.missouri.org
- Montana Coalition Against Domestic and Sexual Violence
  http://www.mcadsv.com/
- Nebraska Domestic Violence Sexual Assault Coalition
  http://www.ndvsac.org/
- Nevada Network Against Domestic Violence
  http://www.nnadv.org/
- New Hampshire Coalition Against Domestic and Sexual Violence
  http://www.nhcadsv.org
- New Jersey Coalition For Battered Women
  http://www.njcbw.org
- New Mexico Coalition Against Domestic Violence
  http://www.nmcadv.org
- New York State Coalition Against Domestic Violence
  http://www.nyscadv.org/
- North Carolina Coalition Against Domestic Violence
  http://www.nccadv.org
- North Dakota Council on Abused Women's Services
  http://www.ndcaws.org/
- Ohio Domestic Violence Network
  http://www.odvn.org/
- Oklahoma Coalition Against Domestic Violence and Sexual Assault
  http://www.ocadvsa.org
- Oregon Coalition Against Domestic and Sexual Violence
  http://www.ocadsv.com/home.htm
- Pennsylvania Coalition Against Domestic Violence
  http://www.pcadv.org
- Rhode Island Domestic Violence
  http://www.courts.state.ri.us/domesticnew/default.htm
- South Carolina Coalition Against Domestic Violence and Sexual Assault
  http://www.sccadvasa.org
- South Dakota Coalition Against Domestic Violence and Sexual Assault
  http://www.southdakotacoalition.org
- Tennessee Coalition Against Domestic and Sexual Violence
  http://www.tcadsv.org

- Texas Council on Family Violence
  http://www.tcfv.org
- Utah Domestic Violence Advisory Council
  http://www.udvac.org/
- Vermont Network Against Domestic Violence and Sexual Assault
  http://www.vtnetwork.org
- Virginia Against Domestic Violence
  http://www.vadv.org
- Washington State Coalition Against Domestic Violence
  http://www.wscadv.org
- West Virginia Coalition Against Domestic Violence
  http://www.wvcadv.org
- Wisconsin Coalition Against Domestic Violence
  http://www.wcadv.org/
- Wyoming Coalition Against Domestic Violence and Sexual Assault
  http://www.users.qwest.net/%7Ewyomingcoalition/index.htm

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